IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA
CIVIL DIVISION

DAVID PASTUSZEK and BRENDA PASTUSZEK, h/w	:	JURY TRIAL DEMANDED
Plaintiffs	:	
vs.	:	
	:	CIVIL ACTION NO. 4:14-cv-01051-MEM
ELECTROLUX HOME PRODUCTS, INC.	:	
and	:	
ELECTROLUX NORTH AMERICA	:	
Defendants	:	

ORDER

AND NOW, this _____ day of _____, 2016, upon consideration of Plaintiffs David and Brenda Pastuszek's Motion *in Limine* to Preclude Portions of Dr. Gene Salkind's Testimony, and any response thereto, it is hereby **ORDERED** and **DECREED** that said Motion is **GRANTED**.

Dr. Gene Salkind is **PRECLUDED** from testifying on the following topics:

1) His opinion on Plaintiff David Pastuszek's credibility;

2) His opinion that Plaintiff David Psatuszek was embellishing or feigning his injuries; and

3) Plaintiff's prior unrelated injuries.

BY THE COURT,

_____
THE HONORABLE MALACHY E. MANNION

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA
CIVIL DIVISION

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ELECTROLUX NORTH AMERICA	:	
Defendants	:	

PLAINTIFFS' MOTION IN LIMINE TO PRECLUDE PORTIONS OF DR. GENE SALKIND'S TESTIMONY

Plaintiffs David and Brenda Pastuszek, by and through their counsel Galfand Berger, LLP, hereby file this Motion *in Limine* to Preclude Portions of Dr. Gene Salkind's Testimony. In support thereof, Plaintiff relies on the attached Memorandum of Law.

Respectfully Submitted,

GALFAND BERGER, LLP

BY: */s/ Richard M. Jurewicz*

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ELECTROLUX HOME PRODUCTS, INC.	:	
and	:	
ELECTROLUX NORTH AMERICA	:	
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PLAINTIFFS' BRIEF (MEMORANDUM OF LAW)
IN SUPPORT OF THEIR MOTION IN LIMINE TO
PRECLUDE PORTIONS OF DR. GENE SALKIND'S TESTIMONY

I. MATTER BEFORE THE COURT

Before this Honorable Court is Plaintiffs David and Brenda Pastuszek's Motion *in Limine* to Preclude Portions of Dr. Gene Salkind's Report regarding the doctor's inappropriate credibility assessments of David Pastuszek, unsupported accusations of embellishment, and any discussion of unrelated prior injuries. In his report, Dr. Salkind makes inappropriate and improper comments on David Pastuszek's credibility, a topic that is solely within the province of the jury. Dr. Salkind cannot be permitted to testify as to his opinion of David Pastuszek's credibility and thereby encroach on the jury's role as evaluator of witness credibility.

His attacks on Plaintiff include accusing him of embellishing his injuries, although Dr. Salkind never establishes a proper factual basis through recognized methods and procedures for making such an opinion, as required by Federal Rule of Evidence 702 and Daubert v. Merrell Dow Pharmaceuticals, Inc. In reading Dr. Salkind's report, it is quite clear that he is nothing more than a mouthpiece for Defense counsel by expressing a theme designed to tarnish the image of David Pastuszek.

Dr. Salkind also cannot be permitted to testify about unrelated prior injuries that have nothing to do with the incident that brings the parties before this Court. Such information is irrelevant and whatever probative value it has is outweighed by its prejudicial effect. The above proffered testimony of Dr. Salkind must be precluded for the reasons identified herein.

II. QUESTIONS PRESENTED

Should this Honorable Court preclude Dr. Salkind from offering opinions on David Pastuszek's credibility, which is a question that is solely a matter for the jury to determine?

Suggested Answer: YES.

Should this Honorable Court preclude Dr. Salkind from testifying concerning his baseless opinion that David Pastuszek is "embellishing" his injuries where Dr. Salkind did not perform adequate testing to make such a finding?

Suggested Answer: YES.

Should this Honorable Court preclude Dr. Salkind from testifying about unrelated previous injuries suffered by David Pastuszek that have no bearing on the present litigation where Dr. Salkind has made no causal connections between the prior injuries and Pastuszek's health issues that arose from the subject accident?

Suggested Answer: YES.

III. FACTS

This matter arises from an August 27, 2013 accident in which Plaintiff David Pastuszek, a local truck driver, was making his first stop of the day and unloading a truck that indisputably had been improperly and negligently loaded by Defendants in such a manner that a commercial washer fell and struck Plaintiff, causing him to fall to the ground. Plaintiff David Pastuszek, who was acting in the course and scope of his employment with J.B. Hunt Transport, Inc., had no role whatsoever in loading or securing the load in the trailer, as it was sealed when he received it to transport to various local retailers. The Electrolux Defendants were solely responsible for loading the appliances and equipment into the truck driven by Plaintiff. A representative of

Defendants admitted that the trailer was improperly loaded and secured. (Bzura Dep., excerpts attached as Exhibit A, at 77-79). Plaintiff's accident was investigated by his employer J.B. Hunt, which concluded that the accident was in no way Plaintiff's fault, but rather that the trailer had been loaded improperly by Defendant's employees. (Exhibit B). As a result of his accident, Plaintiff David Pastuszek suffered injuries to his lower back, including herniated discs in his lumbar spine and severe pain and suffering.

In the course of this litigation, Defendants had Plaintiff David Pastuszek examined by Dr. Gene Salkind for a Defense Medical Exam. Dr. Salkind produced a 10-page report on September 5, 2015. (Exhibit C). A second report from Dr. Salkind dated October 23, 2015 was subsequently produced. (Exhibit D). Dr. Salkind opined in these reports that Plaintiff suffered "at most…a lumbar sprain and strain" as a result of his August 27, 2013 work accident (incorrectly discussed as an August 26, 2013 accident). (Ex. D). He attributed any ongoing problems that Plaintiff is suffering to "lumbar degenerative disc disease," with no further explanation. Defendants retained Dr. Salkind "for a neurosurgical independent medical examination on August 28, 2015." (Ex. C). Dr. Salkind examined and met with Plaintiff only once.

Despite being retained by Defendants for a neurosurgical medical examination, Dr. Salkind offered judgmental commentary on Plaintiff's credibility. Dr. Salkind scoffed at Plaintiff's credibility. (Ex. C at 6). Dr. Salkind also heavily implied that Plaintiff is a liar because Dr. Salkind's interpretation of a particular medical record differs from what Dr. Salkind understood Plaintiff to have told him. (Ex. C at 7). Dr. Salkind was critical of Plaintiff for not divulging an accident to Plaintiff's toe that occurred in 2009, despite the fact that no toe injury is alleged in the present litigation. (Ex. C at 7). Dr. Salkind did not convey exactly what questions about Plaintiff's history that Dr. Salkind asked Plaintiff or how he phrased them, which can

significantly impact how an individual responds. Dr. Salkind again implied that Plaintiff is a liar for not mentioning injuries Plaintiff suffered to his eye while working in 2012. (Ex. C at 7).

Dr. Salkind further accused Plaintiff of "symptom magnification and embellishment" and "feigned weakness." (Ex. C at 4). However, Dr. Salkind did not indicate that he conducted any symptom validity testing (*e.g.*, Waddell's signs) that could *possibly* empirically demonstrate such embellishment. Dr. Salkind reiterates his claims of embellishment based on portions of reports conducted by other doctors for which he was not present. (Ex. C at 9). No other doctor who has examined Pastuszek other than Dr. Salkind has expressed any opinion or made any note in Pastuszek's medical records that would indicate he is embellishing his injuries. Dr. Salkind does not address any other explanations for what he describes as "a disconnect" between the results of an exam a month before the defense medical examination and the results he found. (Ex. C at 9).

Dr. Salkind spent much of his report discussing prior injuries suffered by Plaintiff that have nothing to do with the injuries alleged to have been suffered in the August 27, 2013 accident. Dr. Salkind discussed Plaintiff's two myocardial infarctions (heart attacks), history of smoking, lens implants, and difficulty sleeping, none of which is relevant to Plaintiff's lower back, neck, and left hip injuries from his August 27, 2013 accident. Dr. Salkind also devotes a substantial portion of his opinion to rehashing injuries that Pastuszek suffered in 2009 to his right toe, in January 2011 to his neck and right shoulder, in January 2012 to his eye, in May 2012 to his neck/back and shoulders, and in June 2012 to his hip, right leg, right knee, and right ankle. Dr. Salkind mentions these accidents without explaining how, if at all, any of them are related to Plaintiff's injuries suffered in the subject accident. In fact, Dr. Salkind's only commentary on these prior injuries is that Pastuszek did not tell Dr. Salkind about these injuries.

Plaintiffs' Complaint very specifically identified injuries to David Pastuszek's lumbar spine (lower back), neck, and left hip. The incidents involving injuries to body parts other than those are wholly irrelevant. Dr. Salkind offered no connection between any prior injuries to Plaintiff's lumbar spine, neck, and left hip and his present injuries to those body parts.

Dr. Salkind cannot be permitted to testify concerning these inadmissible topics. The anticipated efforts of Defendants to have Dr. Salkind opine on David Pastuszek's credibility, "embellishment," and unrelated injuries have compelled Plaintiffs to file this omnibus Motion *in Limine*.

IV. ARGUMENT

A. Dr. Salkind inappropriately offers opinions on Plaintiff's credibility and by doing so goes beyond what is permissible for an expert to discuss.

Despite ostensibly being a report of a defense medical exam, Dr. Salkind offers opinions on the credibility of Plaintiff David Pastuszek in a manner that is inadmissible as it encroaches on the jury's job as fact finders. "The credibility of witnesses is generally **not an appropriate subject for expert testimony**." Coney v. NPR, Inc., 312 Fed. Appx. 469, 474 (3d Cir. 2009) (quoting United States v. Adams, 271 F.3d 1236, 1245 (10th Cir. 2001)). "Absent unusual circumstances, **expert medical testimony concerning the truthfulness or credibility of a witness is inadmissible**...because it invades the jury's province to make credibility determinations." Id. (quoting United States v. Beasley, 72 F.3d 1518, 1528 (11th Cir. 1996)). "A **doctor...cannot pass judgment on the alleged victim's truthfulness in the guise of a medical opinion, because it is the jury's function to decide credibility**." Id. (quoting United States v. Whitted, 11 F.3d 782, 785-86 (8th Cir. 1993)). Nevertheless, passing judgment on Pastuszek's credibility is exactly what Dr. Salkind did numerous times in his report.

Throughout what is supposed to be a medical expert report, Dr. Salkind offers commentary on Pastuszek's credibility. On page 6 of his report, Dr. Salkind writes that his perception of an X-ray from 2007 seems to somehow "run[] counter to what the patient told me, and brings his credibility into question." (Ex. C). Directly criticizing Plaintiff's credibility is far beyond the scope of a medical expert and inappropriately delves into an area reserved for the jury. Dr. Salkind goes even further and accuses Plaintiff of lying about prior work-related injuries. Id. at 7 ("Again, this discusses a work-related injury, which the patient specifically denied to me," a comment made in regard to an eye injury). As it is unclear how Dr. Salkind phrased his questions to Plaintiff or whether there may have been a miscommunication, it is inappropriate for Dr. Salkind to assume that Plaintiff intentionally hid information. These sorts of comments and opinions from Dr. Salkind are outside the scope of his expertise and are not the type of testimony that a medical expert is permitted to offer.

By making these inappropriate quips on Pastuszek's credibility, Dr. Salkind is interfering with what is solely within the jury's discretion. See United States v. Jannotti, 673 F.2d 578, 598 (3d Cir. 1982). Whether Pastuszek is telling the truth about his injuries and the events that led to those injuries is solely for the jury to decide. Dr. Salkind cannot be allowed to co-opt that role and unfairly influence the jury's decision with the perceived added weight that comes with supposed expert testimony.

B. Dr. Salkind's opinion that Plaintiff was embellishing his injuries is unsupported by methods and procedures of science.

Dr. Salkind, as a proffered medical expert, cannot offer an opinion that Plaintiff is exaggerating or embellishing his injuries unless he supports that opinion with methods and procedures of science, which he did not. An expert's testimony must conform to the

requirements of Rule 702 of the Federal Rules of Evidence in order to be admissible. Rule 702 states:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:
> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
> (b) the testimony is based on sufficient facts or data;
> (c) the testimony is the product of reliable principles and methods; and
> (d) the expert has reliably applied the principles and methods to the facts of the case.

FED. R. EVID. 702.

The Third Circuit has stated "Rule 702 has three major requirements: (1) the proffered witness must be an expert, i.e., must be qualified; (2) the expert must testify about matters requiring scientific, technical or specialized knowledge; and (3) the expert's testimony must assist the trier of fact." Pineda v. Ford Motor Co., 520 F.3d 237, 244 (3d Cir. 2008). The second prong requires the expert's testimony to be reliable by a preponderance of the evidence and supported by "methods and procedures of science" rather than on "subjective belief or unsupported speculation." In re Paoli R.R. Yard PCB Litig., 35 F.3d 717, 744 (3d Cir. 1994) (quoting Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993)), cert denied 513 U.S. 1190 (1995) ("Paoli II"). The party offering an expert must demonstrate that the expert's conclusions are reliable by a preponderance of the evidence. Paoli II, 35 F.3d at 744.

The trial court "must examine the expert's conclusions in order to determine whether they could reliably flow from the facts known to the expert and the methodology used." Heller v. Shaw Industries, Inc., 167 F. 3d 146, 153 (3d Cir. 1999). An expert's testimony must rest on a reliable foundation of methodology and physical evidence and be relevant to the particular facts

of the case. Daubert, 509 U.S. at 597. There cannot be too great of a gap between the physical evidence and the opinion proffered. General Electric Co. v. Joiner, 522 U.S. 136, 146 (1997). To be reliable, an expert's opinion must be based on scientific methods and procedures, not merely on "**subjective belief or unsupported speculation**." Daubert, 509 U.S. at 590. "[N]othing in Daubert or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert." General Electric Co., 522 U.S. at 146.

In the present matter, Dr. Salkind has made great leaps in rendering his unsupported opinion that Pastuszek was embellishing his injuries. Dr. Salkind did not administer any of the symptom validity tests that are often used in medical examinations. Rather, Dr. Salkind's opinions on Pastuszek's purported malingering are merely *ipse dixit*. Dr. Salkind claims that tests administered over a month prior to the defense medical examination showed better results than what Pastuszek demonstrated at that exam. (Ex. C at 9). However, not only was Dr. Salkind not present at the prior test, he does not explain why other causes for the supposed discrepancy are any less likely than malingering. Rather, Dr. Salkind jumps directly to the conclusion that supports Defendants' narrative and fails to elaborate. He does so without even conducting his own symptom validity test, which would be quite common, especially once Dr. Salkind became suspicious that Pastuszek was not being earnest in his effort. Such tests are designed in an effort to identify non-organic components to pain and take many forms, including distraction tests.

To the extent any physician can identify whether an individual is "feigning" or "embellishing" symptoms, such a finding must be made by conducting actual recognized tests.[1]

[1] In a Congressional Response Report, the Office of the Inspector General noted that the reliability of symptom validity tests is questionable, but acknowledged that the medical community does recognize certain tests. "Although SVTs [symptom validity tests] are commonly referred to as malingering tests, malingering **is just one possible cause of invalid performance**. Office of Inspector General, *The Social Security Administration's Policy on*

Dr. Salkind did not do this, but rather relied solely on his own belief, which is not proper under the standard articulated by Daubert, as described above. Subjective belief and unsupported speculation are insufficient where the proffered expert does not conduct his own testing. See Daubert, 509 U.S. at 590. At best, Dr. Salkind makes a tenuous connection between two separate examinations a month apart. From that, he draws an unwarranted conclusion that the only cause of different flexion numbers is that Plaintiff is intentionally exaggerating his injuries. From such a minimal amount of information and no testing designed to detect symptom magnification, Dr. Salkind is unable to render an opinion supported by facts that Plaintiff is "feigning" or "embellishing." At most, Dr. Salkind can testify to the facts of the test conducted by Plaintiff's treating physician and the results of his examination, but he is not equipped to render an opinion that the reason for the perceived discrepancy is that Plaintiff was embellishing his injuries.

C. Prior incidents of injuries unrelated to Plaintiff's lower back and left hip are irrelevant, so Dr. Salkind must be precluded from discussing those injuries.

Plaintiffs have alleged that David Pastuszek injured his lower back, neck, and left hip as a result of a commercial oven negligently stacked by Defendants falling on him. In Dr. Salkind's report, he goes through exhaustive steps to detail several other unrelated accidents and injuries from David Pastuszek's past that have nothing to do with his lower back. For evidence to be admissible, it must be relevant. Evidence is relevant if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." F.R.E. 401. Evidence that is not relevant is not admissible. F.R.E. 402. Evidence of prior injuries unrelated to the body part(s) injured in the

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Symptom Validity Tests in Determining Disability Claims, A-0813-23094, at Appx. C-1 (Sept. 2013). **Even those tests—which are far more accurate than the *ipse dixit* of Dr. Salkind—cannot identify that the reason for discrepancies in a patient's abilities is necessarily malingering**. Id. at 3. Rather, Dr. Salkind makes this leap only because it suits the narrative advanced by Defendant. In reality, Dr. Salkind cannot render the opinion that Pastuszek is intentionally exaggerating his symptoms. Such a claim would be questionable with proper testing, and is wholly inadmissible without utilizing recognized procedures for symptom validity testing.

present accident is entirely irrelevant. Bair v. Velasco, 2015 U.S. Dist. LEXIS 46582, *3-6 (M.D.Pa. April 9, 2015). Even where evidence is relevant, it must be precluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury. F.R.E. 403.

In Bair, the Middle District precluded the defendant from introducing evidence of a plaintiff's prior injuries to his lumbar spine in an auto accident just over a year before a work-related accident that was the subject of the matter before the Court. There, the plaintiff alleged injuries to his neck, upper back, head, and both knees. Id. Conspicuously absent was any mention of the lower back or lumbar spine. Therefore the Middle District precluded the prior injuries to unrelated body parts as irrelevant. Id.

Dr. Salkind's report goes far beyond discussing prior injuries to those body parts injured in the subject accident. The May 2009 injury to Plaintiff's right toe and the January 2012 injury to Plaintiff's eye are totally irrelevant to the present litigation. These injuries and the accidents that caused these injuries are completely void of any value that would have the tendency to make the existence of any fact of consequence any more or less probable. See F.R.E. 401. As these accidents and injuries are irrelevant, they are inadmissible. F.R.E. 402.

Plaintiff would have no objection to evidence of prior injuries specifically to Plaintiff's lower back being and neck being admitted if the purpose of discussing those injuries was in connection to Plaintiff's present condition. However, it is clear from Dr. Salkind's report that he does not discuss these prior injuries as potential contributing causes for his present condition, but rather as further efforts to attack Pastuszek's credibility for not divulging some of these accidents. Prior injuries are only relevant if they somehow impact the plaintiff's current condition. See Bair, supra at *6 (injuries must be "sufficiently similar to those suffered" in the

incident accident). Dr. Salkind opines that Pastuszek's ongoing medical problems are the result of "lumbar degenerative disc disease"—not any prior accident to his neck or lower back.

Because Dr. Salkind has not connected those prior injuries to Pastuszek's current accident other than in inappropriate attacks on his credibility (see above), he must be precluded from discussing those accidents as well. As Dr. Salkind did not make a causal connection between those accidents and Pastuszek's present injuries, those prior injuries remain irrelevant and must be precluded under Rules 401 and 403. See Celmer v. Marriot Corp., 2004 U.S. Dist. LEXIS 17493, at *4 n.3 (E.D. Pa. Aug. 23, 2004) (granting the plaintiff's motion *in limine* to preclude past injuries where defendant's medical expert "**does not discuss a connection between these past injuries and Plaintiff's present health issues**"). If Dr. Salkind did try to make such a connection at trial, it would be outside the scope of his report. Allowing Defendants to introduce evidence of these prior injuries would be unduly prejudicial to Plaintiffs under Rule 403, as Dr. Salkind and Defendants have offered no connection of any of the prior injuries to the injuries suffered by David Pastuszek in the present litigation. Without such a connection, the prior injuries are lacking any relevance or, to the extent there is any relevance, that relevance is outweighed by the prejudicial effect that would result in the jury being misled and/or misled.

V. RELIEF REQUESTED

For the reasons set forth at length above, Plaintiffs respectfully request that this Honorable Court preclude Dr. Gene Salkind from offering testimony concerning his assessment of David Pastuszek's credibility and any testimony concerning unrelated prior injuries.

Respectfully Submitted,

GALFAND BERGER, LLP

BY: _____/s/ *Richard M. Jurewicz*_____

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ELECTROLUX HOME PRODUCTS, INC.	:	
and	:	
ELECTROLUX NORTH AMERICA	:	
Defendants	:	

CERTIFICATE OF NONCONCURRENCE

I, Richard M. Jurewicz, Esquire, certify that I requested counsel for Defendants' concurrence in Plaintiffs David and Brenda Pastuszek's Motion *in Limine* to Preclude Portions of Dr. Gene Salkind's Testimony pursuant to LR 7.1 and the parties could not agree.

GALFAND BERGER, LLP

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ELECTROLUX HOME PRODUCTS, INC.	:	
and	:	
ELECTROLUX NORTH AMERICA	:	
Defendants	:	

CERTIFICATE OF SERVICE

I, Richard M. Jurewicz, Esquire, hereby certify that a true and correct copy of Plaintiffs David and Brenda Pastuszek's Motion *in Limine* to Preclude Portions of Dr. Gene Salkind's Testimony was sent to counsel below via email:

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EXHIBIT "A"

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DAVID PASTUSZEK & BRENDA PASTUSZEK, h/w, Plaintiff(s), v. ELECTROLUX HOME PRODUCTS, INC., et al., Defendant(s). : NO. 4:14-CV-01051-MEM

May 28, 2015

Oral deposition of MARTIN C. BZURA, held at the law offices of Michael J. O'Connor, 608 W. Oak Street, Frackville, Pa., 17921, beginning at 11:50 a.m., on the above date, before Denise D. Bach, a Registered Professional Reporter and Notary Public.

ESQUIRE DEPOSITION SOLUTIONS
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I N D E X

E X H I B I T S

MARKED	DESCRIPTION	PAGE
(No Exhibits Were Marked.)		

DEPOSITION SUPPORT INDEX

DIRECTION TO WITNESS NOT TO ANSWER

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(None)					

REQUEST FOR PRODUCTION OF DOCUMENTS

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(None)					

STIPULATIONS

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QUESTIONS MARKED

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(None)					

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Mr. Pastuszek was delivering for his drop-offs had been improperly loaded?
A. No.
Q. Did Vince Messina ever tell you that the trailer was improperly loaded, the one that was involved in Mr. Pastuszek's accident?
A. Yeah.
Q. When did he tell you that?
A. I can't remember exactly when.
Q. What did he tell you?
A. That it was improperly loaded and Dave got hurt.
Q. Did he tell you how it was improperly loaded?
A. No; because I will have to step in here in just a minute. It was later that day that that trailer did get returned. Okay. And they called the ops clerk. The ops clerk told me and then Dave Bayer came out, we went over, opened the door, looked at it. At that point, there was stuff laying all over the floor that wasn't secured. But I can't say that didn't happen in transit bringing it back, we just saw there was, you know, stuff left.

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That trailer had to get offloaded, but, like I said, that was late afternoon, that was maybe like 2 o'clock and we were going at 2:30. But I had seen the trailer that got returned, and the load, it was laying all over the place, but it wasn't secure. And I want to say, if I was a guessing man, it was like halfway unloaded.
MS. LINE: Objection.
THE WITNESS: And that's all I seen.
MS. LINE: Can we establish that he is only to answer a question if he knows the answer and not to give a speculative or a guessing answer?
MR. JUREWICZ: If you want to clean that up with him. I'm perfectly happy with what he has to say.
I think all objections except as to the form of the question are reserved.
BY MR. JUREWICZ:
Q. What did Vince tell you, Messina that is, as to why in his belief he thought the trailer that was loaded for Dave Pastuszek to deliver had been improperly loaded?
A. Because something fell on Dave.
Q. And is something ordinarily not supposed to fall if a trailer is loaded properly?
A. Correct.
Q. And the reason for that is either the load's going to be secured by blocking or it's going to be shrink wrapped if it's a multi-load --
A. Stop.
Q. -- or dunnage, something to prevent the second, third and load closest to the bulkhead to shift or move, right?
A. Correct.
Q. When you opened up -- when you saw the trailer that was brought back, did you see any shrink wrapping that was laying around?
A. No.
Q. All right. Did you see anything in the trailer that would indicate that that second load from the bulkhead had been shrunk wrapped?
A. No, I can't say I did.

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Q. Did you see any dunnage in there that would indicate that there was -- that that load had been secured?
A. No.
Q. Did you see any, you know -- do you know what brace poles are?
A. Yes.
Q. Did you see any brace poles securing the load?
A. No.
Q. In the past when your men have loaded trailers, have they used dunnage between, let's say, a first load and second load or second load and third load?
A. If need be.
Q. And have they used shrink wrap between the first load and second load or third load and fourth load?
A. Yes, they did.
Q. And have they used jam poles or braces between the first load, second load or second load and third load, if needed?
A. Yes, they did.
Q. And the decision to use dunnage,

EXHIBIT "B"

Injury Investigation Report

Alpha Code: PASD6	Board Code: 3S@	Name: DAVID PASTUSZEK	
Hire Date: 11/01/2010	City:	State:	

Team Leader/OM:	Mike Forrest/Corporate/JBHunt	Safety Manager/ ARM:	Shawn Would
Fleet/Project Manager:	Rich Hostetler	EventNumber:	873641
Truck Director/VP:	Bryan Schwenk/Corporate/JBHunt	Project:	

Date of Injury:	27 AUG 2013	Date Reported:	27 AUG 2013
Type of Injury (ie Lumbar Strain, Laceration):	DRIVER HAS SEVERE PAIN IN HIS BACK, RIBS, AND HEAD		
Body part affected:	BACK, RIBS, AND HEAD		
Initial Treatment:	Doctors Appointment		
How did injury occur?	DRIVER WAS UNLOADING APPLIANCES FOR 1ST STOP WHEN DRIVER WENT TO GRAB LAST PIECE A WASHING MACHING AND 2 GAS RANGES FELL ON THE DRIVER		
What caused injury (i.e., Slippery surface, faulty equipment, etc.)	AFTER TALKING WITH DRIVER AND WAREHOUSE SUPERVISOR AT RDC THIS WAS A DIRECT RESULT OF IMPROPER LOADING BY SHIPPER. THERE IS NO WAY TO KNOW WHEN A BOX IS GOING TO COLLAPSE FROM WEIGHT AND FALL ON DRIVER! THIS CAM HAPPEN AT ANY TIME WITH NO WARNING!!		
Activity at time of Injury?	UNLOADING		
Factors that contributed to the incident:	IMPROPER LOADING BY SHIPPER AS BOX HAD CRUSH DAMAGE THAT IN TURN LED LED TO APPLIANCES FALLING ON DRIVER AFTER HE MOVED REFRIGERATOR WHICH WAS HOLD THEM UP FROM FALLING		
Witness Name:	N/A		
Account of Incident:	N/A		
Witness Name:	N/A		
Account of Incident:	N/A		
Was proper equipment used for task?	● Yes ○ No		
Explain			
Was personal protective equipment used?	● Yes ○ No		
Explain			
Were appropriate safeguards in place?	● Yes ○ No		
Explain			
Is there a JSA for the activity/task that was performed?	● Yes ○ No		
Explain			
Were JSA steps being followed at the time of the injury?	● Yes ○ No		
Explain			
Had the employee been trained on the JSA and is it documented,	● Yes ○ No		
Explain			
Corrective Actions JSA Training?	○ Yes ● No		
Prevention Plan	NOTHING DRIVER COULD HAVE DONE DIFFERENTLY BECAUSE NOTHING WAS LEANING FORWARD OR OBVIOUSLY SHOWING IT WOULD FALL HAD HE REMOVED REFRIGERATOR		

	Signature	Date
Supervisor		

PASDC David Pastuszek 5 Sep 13

EXHIBIT "C"

LEONARD A. BRUNO, MD / GENE Z. SALKIND, MD P.C.

NEUROLOGICAL SURGERY

727 WELSH ROAD
SUITE 108
HUNTINGDON VALLEY, PA 19006

(215) 914-2320
(215) 914-2365 FAX

09/05/2015

Christine L. Line, Esquire
Dickie, McCamey, and Chilcote, PC.
Attorneys at Law
Plaza 21, Suite 302
425 North 21st Street
Camp Hill, Pennsylvania 17011-2223

Re: Pastuszek v. Eletrolux Home Products, Inc., et. al.
Our File No.: 0024303.0340277

Dear Ms. Line:

I evaluated David Pastuszek in my office for a neurosurgical independent medical examination on August 28, 2015. The patient is a 53-year-old, left-handed male, who was employed as a truck driver for J. B. Hunt, Inc. The patient tells me that in 1994, that he sustained an L4-L5 disc herniation as a result of a work-related injury. The patient underwent an L4-L5 discectomy performed by Dr. Rajjoub and had a good postoperative convalescence. He returned to work in approximately 6-8 weeks.

While employed by J.B. Hunt, Inc, on August 26, 2013, Mr. Pastuszek was unloading a truck. "As I turned around in the truck to place something on to the dock, a washer, refrigerator, and stove fell on me." The patient tells me that he was struck on the left neck, shoulder, and left side of his low back. The patient denied any loss of consciousness nor head trauma. Immediately, "when I took a deep breath it would hurt. I thought I broke a rib." The patient reported the incident to his supervisor and it was suggested that he go home and see how he felt in the morning. He received no medical treatment on the day of the incident.

The following day, the patient awakened complaining of pain in his entire left side and he was black and blue. He was sent to Work Health on August 27, 2013. He was examined and x-rays were taken, and the patient was diagnosed with "spasms and contusion." He was placed out of work for 3 months and ultimately returned to work at light duty. He attended physical therapy 3 times weekly, which he claims afforded him some benefit. He started physical therapy shortly after the work-related incident.

The patient worked at light duty in November 2013 through April 2014. He reported left leg numbness that radiated to his toes and ultimately a lumbar MRI was obtained on December 4, 2013. It was recommended that the patient undergo chiropractic treatment with massage therapy which afforded him only transient relief.

The patient was ultimately referred to Bruce H. Levin, MD at the Pennsylvania Spine and Headache Center. Dr. Levin performed L4-L5 and L5-S1 transforaminal epidural steroid injections on December 17, 2013 and February 6, 2014. The lumbar injections initially gave the patient good relief, but as his pain persisted, Dr. Levin performed a lumbar discogram/CT scan from L2-L3 through L5-S1 on April 29, 2014. The patient then underwent 2 further lumbar injections with only temporary relief.

The patient underwent a consultation with James McInerney, MD, a neurosurgeon at the Hershey Medical Center. On June 18, 2014, the patient underwent an L5-S1 microdiscectomy. He had an initial good postoperative course, but then began to have intermittent fevers, increased pain, and purulent wound drainage.

Consequently, the patient presented to the Geisinger Medical Center on July 3, 2014. The patient was evaluated by Shelly Diane Timmons, MD, a neurosurgeon. She found that the patient had grossly purulent brownish-tan drainage that was easily expressed from the wounds. It was painful and was under pressure and a large volume had been expressed from the wound. Mr. Pastuszek stated that his left leg pain resolved with the surgery, but that he had some typical residual intermittent numbness. It was Dr. Timmons assessment that the patient had a deep space surgical wound infection and she took the patient to the operating room emergently for an incision and drainage, as well as wound cultures. The cultures were significant for methicillin-sensitive Staphylococcus aureus, and the presumption was that the patient would be given intravenous antibiotics for at least 2 weeks. The patient was started on vancomycin and cefepime intraoperatively. The Infectious Disease consultants converted Mr. Pastuszek to Keflex by mouth, and the patient was discharged to home on July 5, 2014. When Dr. Timmons evaluated the patient on July 8, 2014, she felt that he had an excellent result with respect to resolution of his radicular pain and early wound healing. CRP had decreased from 75 to 14, and erythrocyte sedimentation rate was approximately 42. The patient's white blood cell count decreased from 19.10 to 11.8.

Postoperatively, the patient did more physical therapy, but began to experience difficulty with bowel and bladder function. A repeat lumbar MRI was performed, and the patient claimed that "something was pinching a nerve." According to Dr. Timmons, the patient had the picture of an acute L4 and L5 radiculopathy congruent with

degenerative disk, probable small HNP, and foraminal stenosis at L4-L5. He also had a new right L3-L4 disc protrusion, but this was felt to be asymptomatic. Dr. Timmons planned for a left L4-L5 decompression, foraminotomy, and possible microdiscectomy on April 9, 2015. The patient had a good postoperative recovery with improved bowel and bladder function. He had started a program of physical therapy 3 times weekly which continues to the present time.

As of the present time, the patient's chief complaint is that of left-sided low back pain, hip pain, and left lateral calf pain. He tells me that he feels about the same as he did before surgery. The patient admits to spasms about his left lateral thigh. He tells me that his pain is constant, but that it varies in intensity. He describes it as annoying, and tells me that his complex is 50% left-sided low back pain and 50% left hip pain. The patient rates his pain as a 6-7 on a scale of 0-10. He claims that his low back pain is increased with walking less than 0.5 mile. His pain is improved with medication, hot compresses, and a TENS unit. The patient feels that his pain complex has affected his activities of daily living. He cannot take care of his horses, cannot fish, and he cannot drive a truck any longer. He has been out of work since approximately April 2014.

The patient admits to numbness of the left great toe, as well as the arch and ball of the left foot. He denies weakness nor bowel or bladder dysfunction.

The patient specifically denied any prior or subsequent traumas. He tells me that in 1994, he sustained a work-related injury. He saw the company physician and was diagnosed with a lumbar disc herniation. As previously stated, he underwent an L4-L5 discectomy and returned to work full time, full duty.

Past medical history is significant for 2 myocardial infarctions in 1997 and in 2009. The patient has undergone angioplasty without stent placement, multiple lumbar surgeries as previously detailed, an appendectomy, and cataract surgery with lens implants. He has no known drug allergies. The patient takes gabapentin t.i.d., tizanidine t.i.d., cyclobenzaprine p.r.n., and tramadol 2-3 times per day. He took all of his medicines at 9:45 a.m., and I interviewed him at approximately 1:50 p.m.

MLC

Social history is significant for one-half pack per day tobacco ingestion intermittently for 35 years. The patient drinks alcohol rarely. He does not use recreational or intravenous drugs.

Family history is noncontributory.

Review of systems is significant for lens implants and difficulty sleeping.

On physical examination, I found the patient to be awake, alert, and in no acute distress. He exemplified significant signs of symptom magnification and embellishment. Examination of the patient's low back revealed a well-healed lumbar laminectomy wound in the midline spanning L4 through S1. There was no erythema, subcutaneous collection, nor tenderness. There was no spinous process, paravertebral, nor sciatic notch tenderness. There was no paravertebral spasm. Straight leg raising was negative to 90 degrees bilaterally. Despite this, forward flexion was accomplished to only 40 degrees with complaints of low back pain. Motor examination revealed normal tone and bulk. Despite this, there was diffuse give-way weakness in the muscle groups tested in the entire left leg. This included the iliopsoas, quadriceps, hamstring, tibialis anterior, extensor hallucis longus, and the gastrocnemius soleus complex. Strength was 5/5 in the same muscle groups on the right. Sensation was intact to light touch and pinprick. Deep tendon reflexes were +2 and equal at the knees and ankles. The patient's gait was steady and non-antalgic. Despite this, heel and toe walking was difficult secondary to feigned weakness in the left leg.

I was able to review the following documents pertinent to the care of David Pastuszek:

1. The complaint;
2. The deposition transcript of David Pastuszek, dated December 22, 2014;
3. The deposition transcript of Brenda Pastuszek, David's wife, dated December 22, 2014;
4. The plaintiff's responses to interrogatories;
5. Plaintiff's rule 26 initial disclosures-including Workmen's Compensation for prior/current claims;
6. The plaintiff's responses to request for production of documents;
7. Medical records from the Sunbury Community Hospital;
8. Records from the Shamokin Dam Health Center;
9. Medical records from Pagana and Pagana-DeFazio Family Practice, LLC;
10. Medical records from the Evangelical Community Hospital;
11. Records from the Schuylkill Medical Center;
12. Medical records from Sun Orthopedics;
13. Medical records from Phoenix Rehab;
14. Medical records of Bruce H. Levin, MD, the Pennsylvania Spine and Headache Center;
15. Records from Milton S. Hershey Medical Center, James McInerney, MD;
16. Records from the Geisinger Medical Center.

I was personally able to review the following diagnostic studies pertinent to the care of David Pastuszek:

1. An x-ray of the lumbar spine dated August 28, 2013. There was evidence of a lumbarized sacrum. There was also evidence of disc space narrowing at L4-L5 with evidence of endplate sclerosis and osteophytic disease. There appeared to be evidence of prior surgical intervention at the L4-L5 level;
2. An MRI of the lumbar spine both with and without gadolinium dated September 16, 2013. To my reading, there was evidence of diffuse degenerative disc disease. In the body of L2, there appeared to be a hemangioma. At L2-L3, there was evidence of disc desiccation with a bulging annulus. This gave rise to mild central spinal stenosis with mild neural foraminal stenosis. At L3-L4, there was evidence of disc desiccation with a central and right-sided bulging annulus/disc protrusion. There was mild-to-moderate central spinal stenosis with moderate left and moderate right neural foraminal stenosis. At L4-L5, there was evidence of prior surgical intervention on the left with a bulging annulus and a left-sided disc protrusion. There was associated hypertrophy of the facet joints, with severe bilateral neural foraminal stenosis. At L5-S1, there was evidence of a bulging annulus and an annular tear. There appeared to be encroachment on the left lateral recess secondary to scar tissue, and the disc protrusion. There was severe left greater than right neural foraminal stenosis. There was clearly evidence of bulging annuli and disc protrusions, as well as epidural scar tissue from the prior surgery, but there was clearly no evidence of an acute herniated nucleus pulposus;
3. A CT scan of the lumbar spine dated October 1, 2013. There was evidence of diffuse degenerative disc disease without any acute fracture or spondylolisthesis. There was both central as well as neural foraminal stenosis, without an appreciable difference compared to the prior lumbar MRI;
4. An MRI of the lumbar spine both with and without contrast dated April 3, 2014. There is again evidence of diffuse degenerative disc disease as evidenced by diffuse disc desiccation. There is a persistent incidental hemangioma in the body of L2. There is persistent scar tissue identified at L4-L5 with a protruding disc and significant bilateral foraminal narrowing secondary to a disc/osteophyte complex. At L5-S1, there is a bulging annulus with a disc/osteophyte complex that is mildly effacing the L5 nerve root. There is no change compared to the prior MRI and CT scan. Of interest, the radiologist who interpreted the film, Charles Austin, MD, did not have the luxury of reviewing the prior lumbar studies;
5. An MRI of the thoracic spine dated December 4, 2013. To my reading, this was a normal study;
6. An MRI of the lumbar spine without gadolinium dated December 4, 2013. The findings revealed no acute disc herniation, but rather the

persistent degenerative disc disease giving rise to varying degrees of both central and lateral recess stenosis;
7. A CT scan of the lumbar spine dated April 29, 2014. There was evidence of decreased disc height at L4-L5. There were bulging annuli from L2-L3 through L5-S1, and there was no significant change compared to the lumbar MRI performed December 4, 2013. There was specifically no evidence of an acute herniated nucleus pulposus;
8. An MRI of the lumbar spine dated July 30, 2014. This revealed stable findings at most levels, but there was now evidence of a left L5-S1 hemilaminectomy. There was postoperative epidural scar tissue with mild-to-moderate narrowing of the thecal sac. There was clearly hypertrophy of the facet joints. There was increased post gadolinium signal in the soft tissues posterior to the spinal canal. There did not appear to be any significant abscess;
9. An MRI of the lumbar spine both with and without contrast dated October 17, 2014. There were postsurgical changes identified at L4-L5 and L5-S1. There was epidural scar tissue more marked on the left at L5-S1, that was encasing the left S1 nerve root. There was moderate-to-severe left L5-S1 foraminal narrowing with diffuse degenerative changes; there was specifically no evidence of an acute herniated nucleus pulposus;
10. Flexion and extension lumbar spine films dated October 28, 2014. There was evidence of diffuse degenerative disc disease in the lumbar spine. There did not appear to be any movement in flexion or extension.

There are certain points that bear enumeration from my review of the records. The patient specifically denied to me any prior or subsequent traumas, other than the incident in 1994 at work. A note from the Sunbury Community Hospital dated, June 8, 2007, revealed that Mr. Pastuszek complained of back pain when he fell off of a truck at work. He had a history of prior back pain and the impression was that of low back pain and a lumbar contusion. An x-ray of the lumbar spine was taken at the Sunbury Community Hospital on that date, which revealed osteoarthritic changes of the lower lumbar spine. This clearly runs counter to what the patient told me, and brings his credibility into question.

From an entry at the Sunbury Community Hospital dated September 20, 2008, the patient complained of back pain which started 2 days ago at work. There was radiation to the leg, and the patient sought consultation with a chiropractor on September 19, 2008. The impression was that of acute myofascial lumbar strain.

On September 26, 2008 at the Evangelical Community Hospital, the patient was evaluated at Occupational Medicine. He complained of low back pain and gave a history of prior lumbar disc surgery by Dr. Rajjoub in 1995. The patient claimed that after the procedure, that

he had no recurrence of his symptoms in either his back or his legs. The patient was moving a range hood at a pharmacy, when Mr. Pastuszek and a co-worker attempted to pick up the range hood to test its weight. A few days later, the patient had pain and cramping in his low back. He was seen by a chiropractor and was evaluated at the Sunbury Community Hospital Emergency Room. He continued to complain of discomfort in his low back, but denied any pain in his legs. He was diagnosed with a lumbar strain.

In the Sunbury Community Hospital Emergency Room visit dated May 7, 2009, the patient complained of right toe pain when he ran over his great toe with a pallet jack at work. Again, this discusses a work-related injury, which the patient specifically denied to me. MIL

From reviewing a note authored by Dr. Pagana on May 27, 2010, the patient was a truck driver and did a lot of heavy lifting throughout the day with the moving company that he worked for until this month. He is changing jobs and will be delivering appliances to the department stores which will also require lifting heavy equipment/appliances.

In a note authored by Dr. Pagana at the Shamokin Area Community Hospital, on January 10, 2011, Mr. Pastuszek fell on ice and complained of neck and right shoulder pain. He also had headache and joint pains and was diagnosed with a shoulder sprain, cervical sprain, and multiple contusions. He had no evidence of an intracranial injury. On January 12, 2011, this was another Workmen's Compensation injury. At the Sunbury Community Hospital on January 12, 2011, the patient discussed that he slipped on ice while walking back to the truck on January 10, 2011, while employed by J.B. Hunt. "I was walking back to the truck and both feet went out from under me" landing more on the right than the left. He complained of neck/back and right shoulder pain. The patient was diagnosed with a right shoulder and cervical spine sprain and was not considered disabled as a result of the injury. He was treated with physical therapy through December 1, 2011. MIL

On January 30, 2012, the patient presented to the Geisinger Medical Center Emergency Room with complaints of eye pain. A trailer strap became loose and struck the patient in the eye. Again, this is a work-related injury that the patient never disclosed to me.

On May 3, 2012 from the Shamokin Dam Health Center physical therapy note, the patient complained of neck/back and shoulders pain which was identical to the pain when he injured himself in January 2011. It was felt that the symptoms were directly related to the workmen's compensation injury of January 2011. MIL

UN Notes

On June 22, 2012, while evaluated at the Schuylkill Medical Center, Mr. Pastuszek stepped off a tractor trailer and his foot got caught in the bracing. He fell backwards, and the patient has right leg got twisted and the patient landed on his left hip. He complained of pain to the left hip, right leg, right knee, and right ankle. He was diagnosed with a right ankle sprain and left hip sprain. An x-ray of the pelvis and left hip revealed mild degenerative changes of the hips bilaterally without evidence of acute fracture of the pelvis or left hip. This again became a Workmen's Compensation claim. In the notice of compensation payable, dated July 5, 2012, the patient was injured on June 22, 2012, and sustained an injury to his right ankle, right knee, left hip, and lumbar spine. He fell as he was getting out of the trailer and his right ankle got caught on the bumper. By July 24, 2012, on a Phoenix Rehab discharge summary, the patient had improved low back pain levels and return to unrestricted work by his referring provider. The fact that a mention is made that his low back pain improved, runs counter to the history that the patient gave me, as he clearly denied any issues with his back or leg after the lumbar surgery, and prior to August 27, 2013 injury.

From my review of the Occupational Medicine Clinic visit dated August 28, 2013, it discusses the August 27, 2013, work-related injury. The patient complained of pain after an appliance toppled on him. His primary problem was in the thoracic region. He had moderate, constant pain that he rated as a 7/10. His 2nd problem was pain in the lumbar region that was moderate and intermittent, and was worsened with walking. His 3rd problem was that of left hip pain as he had contused his left hip and it was strained during the incident. On examination, the patient had no abrasion in the thoracic spine, nor is there bruising or erythema. There was no open wound or swelling. The patient's range of motion was normal. He did have spasms in the thoracic region. In the lumbar region, there was pain and spasm, but range of motion was normal. The left hip revealed pain to palpation with a normal range of motion. The patient underwent an x-ray of the chest which showed no rib fractures. He underwent a thoracic x-ray which showed no fractures and it was considered to be an unremarkable examination. The patient underwent lumbar spine x-rays which showed no acute fractures, there was transitional vertebral bodies, and there was evidence of discogenic disease at the L4-L5 level. The patient was diagnosed with a contusion of the chest wall, left scapula, lumbar spine, as well as a strain of the thoracic spine, lumbar spine, and left hip. It was recommended that the patient return to restricted duty.

The patient returned to Occupational Medicine Clinic on August 29, 2013, with persistent complaints. Physical Therapy was ordered and x-rays disclosed no evidence of acute injury. The lumbar films denoted prior disc pathology. It was recommended that the patient performed

restricted work duty with limited bending and twisting, and no lifting, pushing, or pulling greater than 20 pounds.

From my review of an office note at Sun Orthopedics, dated October 14, 2013, the patient complained of back pain. Mr. Pastuszek stated that several appliances in a trailer fell on him pushing him to the floor. He had help from someone who was there on the loading dock and was not able to drive his truck home. Eighteen years earlier, he had surgery to his low back by Dr. Rajjoub. A lumbar MRI showed slight bulging of disk material at both L4-L5 and L5-S1, neither of which represented surgical pathology. Consequently, the patient was restored to modified duty, working 2-4 hours per day, and lifting 10-20 pounds.

I was able to review a modified Oswestry Low Back Pain Disability Questionnaire dated November 18, 2013. There was a rating of 58% which is indicative of symptom magnification and an exaggerated response to a patient's pain complex.

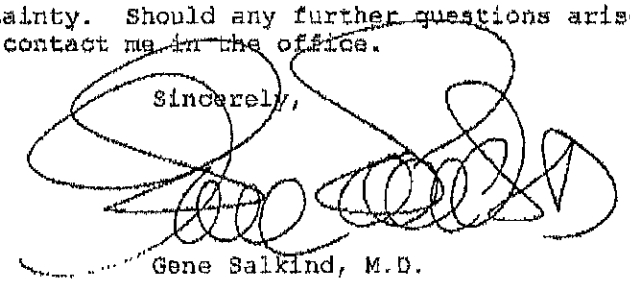
From reviewing the evaluation of Dr. Timmons at the Geisinger Medical Center, and a note dated July 28, 2014, the patient was found to be in no acute distress. His incision was healing well without signs of infection, his motor examination was 5/5, his sensation was grossly intact to light touch, and his gait was intact. An MRI was reviewed which revealed ongoing soft tissue inflammation as expected, as well as disc removal from the prior surgery. These were expected findings. Of importance, is the fact that Dr. Timmons found a normal neurologic examination. This was again borne out on August 11, 2014, October 14, 2014, December 10, 2014, and more importantly on July 25, 2015. On examination, the patient's wound was well healed, his back flexion and extension were good, and he was able to get up and down from a chair without difficulty. The patient had 5/5 strength of the bilateral iliopsoas, hamstrings, quadriceps, tibialis anterior, gastrocnemius-soleus complex, and the extensor hallucis longus. This examination is in sharp contradistinction to my examination which occurred approximately 1 month later, on August 28, 2015. I found a well-healed wound, negative straight leg raising, forward flexion limited to 40 degrees with complaints of low back pain, and diffuse give-way weakness of all of the muscle groups tested in the left lower extremity. Furthermore, reflexes were completely normal. This further points out to me that the patient manifested dramatic signs of symptom magnification and embellishment. Straight leg raising was negative to 90 degrees bilaterally militating against any nerve root compression. It is impossible to have the dramatic feigned weakness in August 2015 when there was a normal examination by the patient's treating physician one month earlier. There is a disconnect between totally normal straight leg raising to 90 degrees and forward flexion limited to 40 degrees. In addition, the patient's deep tendon reflexes at the knees and ankles were 2+ and equal, which is

normoactive and symmetrical. Deep tendon reflexes are the only portion of the neurologic examination that the patient cannot alter. It is not surprising to me that in fact his deep tendon reflexes were normal. Due to the signs of symptom magnification and embellishment, it makes it extremely difficult to assess the veracity of the patient's complaints.

It is my impression, that as a result of the work-related incident dated August 26, 2013, that at most the patient sustained a lumbar sprain and strain. He has a long history of injuries to his low back which the patient did not disclose to me. This withholding of information, coupled with the symptom magnification on examination, make it very difficult to assess the veracity of the patient's complaints. I believe that the patient's ongoing complaints are due to his preexisting, unrelated lumbar degenerative disc disease. On none of the diagnostic studies that I reviewed, did I find any evidence of an acute herniated nucleus pulposus. I do not believe that the patient requires any further treatment with respect to his alleged work injury, and feel that he may return to his pre-injury position without restriction. Taking the multiple surgeries, as well as his preexisting, unrelated lumbar degenerative disc disease, he should be restored to light duty work, with no lifting greater than 20 pounds. This is clearly on the basis of his lumbar degenerative disc disease, and bears no relationship to the work incident.

The above opinions have been stated within a reasonable degree of medical certainty. Should any further questions arise, please do not hesitate to contact me in the office.

Sincerely,



Gene Salkind, M.D.

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DT: 09/05/2015 12:53:55

EXHIBIT “D”

Gene Salkind, MD
727 Welsh Road – Suite 108
Huntingdon Valley, PA 19006
215 914-2320 Fx 215 914-2365

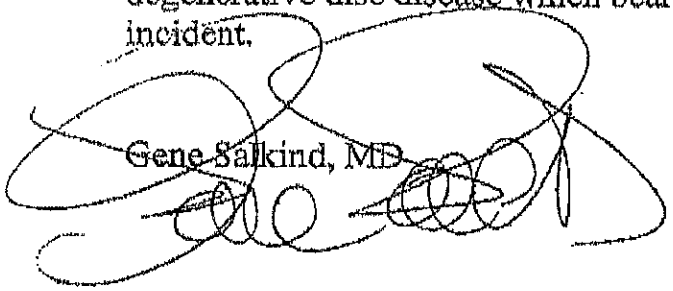
October 23, 2015
To: Christine Line, Esq

Re: Pastuszek v. Eletrolux Home Products, Inc., et.al.

I have reviewed the following with reference to the above mentioned case:

- The expert report, and supplemental report, of Leonard A. Bruno, MD;
- The expert report and CV of Michael K. Napier, Sr.;
- EMG report of Pasquale A. Colavita, DO;
- Report of Michael J. Dunigan, DC;
- The report and CV of Bruce H, Levin, MD;
- The CV and Vocational Assessment of Sean C. Hanahue MA, CDMS, CRC, BCPC, LPC, ABVED;

After review of the above materials, my opinion, within a reasonable degree of medical certainty, remains the same in that as a result of the work-related incident dated 8/26/13, that at most the patient sustained a lumbar sprain and strain. I do not believe that the patient requires any further treatment with respect to his alleged work injury, and feel that he may return to his pre-injury position without restriction. He should be restored to light duty work, with no lifting greater than 20 pounds, based on his lumbar degenerative disc disease which bears no relationship to the work incident.



Gene Salkind, MD